

Lyndale Care Limited - Lyndale Villa and Manor

Introduction

This report records the results of a Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Lyndale Care Limited
Premises audited:	Lyndale Villa Lyndale Manor
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 October 2015 End date: 9 October 2015
Proposed changes to current services (if any):	Proposed change of ownership from Lyndale Rest Home Limited to Lyndale Care Limited.
Total beds occupied across all premises included in the audit on the first day of the audit:	47

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

General overview of the audit

Lyndale Villa and Lyndale Manor provide rest home level care, including independent living units and rest home dementia level care and for up to 56 residents. The facilities are currently operated by Lyndale Rest Home Limited. The services are managed by a general manager.

This provisional audit was undertaken to establish the extent to which the existing provider conforms to the requirements of the Health and Disability Services Standards and the District Health Board (DHB) funding contract prior to a change in ownership. This audit also established how well prepared the prospective provider is to provide a health and disability service. The prospective provider, the director for Lyndale Care Limited was interviewed during this audit.

The audit process included the review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Residents and family members interviewed provided positive feedback on the care provided.

There are eight areas identified during this audit that require improvement relating to: staff documentation; ongoing education; resident documentation; planned activities; referral of residents for reassessment at Lyndale Manor; and repairs and maintenance at both sites.

Consumer rights

Systems and processes are in place to ensure that the independence, personal privacy and dignity of residents are respected, and that residents are kept safe. There is regular and ongoing training on residents' rights, and staff demonstrated a good understanding of how these could be implemented in their daily practice. During the audit visit, residents were observed to be treated in a professional and respectful manner.

Services provided to residents are of an appropriate standard. There was evidence of open and ongoing communication with residents and families.

The general manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Lyndale Rest Home Limited is the governing body and is responsible for the services provided. A business strategic plan and quality and risk management systems are fully implemented at Lyndale Villa and Lyndale Manor and documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly reporting by the general manager to the governing body.

The prospective provider advised Lyndale Care Limited will be the governing body. The new owner and director for Lyndale Care Limited advised they are proposing to purchase the facility and assume responsibility for the provision of services from late November 2015. The prospective provider owns and manages another aged care facility in the region. A business plan, a

transition plan with timeframes, a quality and risk management plan and an organisational structure for the prospective provider was reviewed.

The facility is managed by an experienced general manager who is non-clinical and has been working in this role for many years. The general manager is supported by a clinical leader who is a registered nurse and a quality assurance coordinator. The clinical leader is responsible for oversight of the clinical service in the two facilities.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Staff meetings are held and there was reporting on numbers of various clinical indicators, quality and risk issues and discussion of any trends identified in these meetings. Graphs of clinical indicators were available for staff to view along with meeting minutes.

There are policies and procedures on human resources management, however not all required documentation was sighted on staff files. Staff are required to complete the New Zealand Qualifications Authority Unit Standards. An in-service education programme is provided for staff. Staff files evidenced low attendance at training sessions and there was no evidence of restraint competencies for clinical staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The general manager and registered nurses are rostered on call after hours.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries into residents' clinical records was legible.

Continuum of service delivery

Registered nurses are on duty each weekday, for three hours each weekend day, and are available on call at all other times to guide care delivery staff. Continuity of care is promoted by the updating of residents' progress notes every shift, verbal handovers

and facility diaries. Care plans are individualised based on a range of clinical information and include input from residents and families. The evaluation of nursing care plans within required timeframes, the referral of residents for reassessment of the level of care needed when their condition changes, and residents requiring specialist dementia care having detailed care plans related to minimising episodes of challenging behaviour, are all areas for improvement.

The kitchens in both facilities are maintained in a clean and hygienic manner and all aspects of food service delivery are well managed. The individual food preferences and dietary needs of residents are respected and catered for and residents/families reported their satisfaction with the food services.

Medications are prescribed in accordance with legislative requirements and safe practice requirements. Medications are administered by registered nurses and senior caregivers who have been assessed as competent in relation to medicines management. The management of medications is safe and appropriate, with the exception of ensuring that medications are discarded when past their 'best-before' date, which requires improvement.

Three activities staff manage the activities programme offered across the service, which includes a variety of individual and group activities. Residents are encouraged to maintain their links with the community and a facility van is available to take residents on outings or attend activities in the community. For residents requiring specialist dementia care, the development of individual 24-hour activities plans for each resident, and ensuring an ongoing activities programme when activities staff are not on site, are areas for improvement.

Safe and appropriate environment

A current building warrant of fitness is displayed at both sites. A preventative and reactive maintenance programme includes equipment and electrical checks. As a result of water damage, repairs and maintenance is required at both Lyndale Villa and Lyndale Manor.

All residents' bedrooms provide single accommodation and most have full ensembles. Residents' rooms have adequate personal space provided. A number of lounges, dining areas and alcoves are available. External areas are safe and there are shaded areas available and seating is provided.

Appropriate call bell systems are available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are in place to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

There are documented guidelines on the use of restraints and enablers and behaviours of concern. Currently there are no residents using restraint or enablers. In the event of restraint use, the required approval, consent, assessment, monitoring and review would be completed.

Infection prevention and control

Infection prevention and control systems are in place, with staff offered regular education related to infection control. Personal protective equipment is freely available to staff, and additional supplies are on site should there be an infection outbreak. The infection control programme is reviewed annually. The infection control coordinator is a registered nurse. Infection surveillance is undertaken on an ongoing process, and reported monthly to senior management and staff.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	3	3	0	0
Criteria	0	85	0	4	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The orientation programme for new staff includes education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code), as confirmed in staff interviews and orientation checklists. Education on the Code is also made available to staff annually, as confirmed in the education plan and training records. Education on the Code was last undertaken in September 2015. Refer also to Criterion 1.2.7.5.</p> <p>On interview staff demonstrated a clear understanding of the Code and were able to explain how this was incorporated into their everyday practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Well-documented policies guide service providers in relation to informed consent. Completed consent forms were seen in all residents' records reviewed. Each resident, and/or their enduring power of attorney (EPOA), completes a comprehensive consent form at the time of admission. Consent is reviewed on an as-required basis, such as when a resident's needs change, or additional medical/surgical treatment is</p>

		<p>required. Residents and staff interviewed confirmed they were consistently given the opportunity to make informed choices and that their consent was obtained and respected.</p> <p>The sighted admission agreement, which is completed by each new resident and/or their family member, contains service inclusions and exclusions. A database is maintained to ensure that signed admission agreements are held for every resident.</p> <p>The clinical leader advised that only one resident currently has an advance directive, and this has been incorporated into their plan of care. All residents' records reviewed contained a completed resuscitation status form, which included information about resident and family input into the decision, and had been authorised by the doctor. It is recommended that a process is established to review these forms regularly.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this. As part of the admission process all residents are given a copy of the Code, which includes information on the Advocacy Service. Copies of the Advocacy Service brochure were also available at reception.</p> <p>Staff training records confirmed that information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. Refer also to Criterion 1.2.7.5. Staff demonstrated familiarity with the services offered by the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has unrestricted visiting hours and visitors are encouraged. All family members interviewed stated that they visited regularly, and always felt welcome.</p> <p>If residents are well enough, they are encouraged to maintain their community interests, and to visit families. Processes are in place to facilitate rest home residents having overnight stays with families where appropriate.</p>

		<p>Outings are organised using the service's van that enable residents to participate in community events, while community groups and entertainers visit the facility regularly.</p> <p>Residents are also supported to access health care services outside of the facility, such as visits to the dentist or to specialist medical services.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The general manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that included four complaints for 2015 and these were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The complaints process was readily accessible and/or displayed. Review of staff meeting minutes provided evidence of reporting of any complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p> <p>The general manager advised there have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB, Accident Compensation Corporation (ACC) Coroner or Police since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The prospective provider demonstrated knowledge and understanding of consumer rights.</p> <p>As part of the admission process, each new resident/family is provided with a copy of the Code which also includes information on the Nationwide Health and Disability Advocacy Service (Advocacy Service). This information is discussed with them by management or senior clinical staff who answer any questions that may arise. Further discussions and explanations are provided as required by the individual resident and/or their family. Copies of the Code, and the information on</p>

		<p>the Advocacy Service, were easily accessible at both facilities. The results of the 2014 satisfaction survey indicated that residents/families were very satisfied that residents' rights were being respected.</p> <p>All residents and family members interviewed stated they understood residents' rights, and had been given information about this, and the Advocacy Service. They also confirmed that if they did have any concerns they would feel comfortable raising these with staff, especially with the General Manager.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>A review of residents' records confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their lifestyle plan. There was a strong emphasis in these plans on maintaining and promoting residents' abilities. Residents and families interviewed confirmed their involvement in the development of these plans, and of being kept informed of residents' progress towards meeting identified goals.</p> <p>All rest home residents and those receiving specialist dementia care have a private room and are encouraged to personalise those rooms. Residents and families stated on interview that they were treated respectfully and their individual needs were met. One family member commented that "there has been nothing but respect shown to my father". During the audit visit, staff were observed to maintain resident privacy when undertaking personal cares, to address residents by their preferred name, and to knock on closed doors before entering. Staff were also observed to interact with residents in a polite and appropriate manner.</p> <p>Privacy of resident information was maintained. All residents' clinical files are kept in staff offices, personal information in administration files are password protected; archived records are secure, and staff handovers are undertaken in a manner that maintains privacy of information.</p> <p>The service's policy related to abuse and neglect was well understood by those staff interviewed, and information about this is included in the individual employment contracts. Staff were able to provide examples of what would constitute abuse and neglect and the actions they would</p>

		take if they suspected this. Staff education related to abuse and neglect was last completed in April 2015. Refer also to Criterion 1.2.7.5.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are currently no residents who identify as Maori, but there are protocols in place should they be required. The quality manager advised that the service presently employs at least one staff member who identifies as Maori. The Maori Health Plan (last reviewed in November 2014) includes the names and contact details of a designated Kaumātua for the service, and the names and contact details of relevant staff at the Wairarapa District Health Board. Staff also consult with individual families as to their preferred appropriate cultural support.</p> <p>Cultural beliefs and related requirements are incorporated into the resident's admission assessment, and that information is then incorporated into the relevant section of the lifestyle care plan. Care delivery staff advised that deceased residents' rooms are always blessed by a designated staff member prior to the next resident being admitted. If a new Maori resident wished to have an additional Maori blessing of their room this would be arranged.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Personal preferences and special requirements were included in all care plans reviewed, together with details of interventions to ensure these needs were met. There was also evidence in those care plans of the resident and/or their family being involved in their development.</p> <p>All residents and family members advised on interview they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected, such as the resident's preferred name always being used.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>All residents and family members interviewed advised that residents were free from any type of discrimination or exploitation. Staff members' individual employment agreements clearly document the service's expectations related to keeping residents safe. Staff reported that this</p>

		<p>was discussed with them as part of their orientation/induction process, and then as part of the ongoing training programme.</p> <p>When interviewed, staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>On interview, the doctor confirms his satisfaction with the standards of service provision and confidence that residents are not discriminated against in any manner.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has a range of current clinical policies that reflect best-practice. The service also has well-established linkages with a range of specialist clinical staff from the Wairarapa DHB, including wound management, mental health for the older person and the cardiac outreach service.</p> <p>The doctor and residents/families confirmed their satisfaction with the standard of care provided to residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The residents' files reviewed included evidence of open disclosure and effective communication with residents/families. All family members interviewed stated they were informed in a timely manner about any changes to the resident's status. The clinical leader also advised that families are sent written information on the outcomes of the six-monthly resident review process. All accident/incident forms reviewed in resident files included documentation about communication with family. There was also evidence of resident/family input into the care planning process. Regular meetings for rest home residents provide another forum for communication. The general manager advised that service newsletters are published four times a year.</p> <p>The clinical leader advised that interpreter services were able to be accessed from the Wairarapa DHB when required.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lyndale Care Limited is proposing to purchase this business and assume responsibility for the provision of services from the 23 November 2015. The prospective purchaser owns and has managed another aged care facility in the region, since 2011. The existing provider and prospective provider advised they have had discussions with the District Health Board (DHB) portfolio manager concerning transfer of the aged related residential care (ARC) contract to the prospective purchaser.</p> <p>A 'Business Strategic Plan 2013-2016' and a 'Quality and Risk Management Plan 2015 -2016' includes goals and objectives for the current provider were reviewed.</p> <p>A 'Lyndale Care Limited Business Strategic Plan' for the prospective provider was also reviewed along with a transitional plan that details the timeframes. The director for Lyndale Care Limited advised they are not proposing to make changes to key personnel and staffing levels.</p> <p>Also reviewed were documented values, mission statement and philosophy. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>The general manager is non-clinical and has been in their position since 1994. The clinical leader who is a registered nurse has been in their position since 2011. The clinical leader is responsible for the clinical service at both sites. The general manager is supported by the clinical leader and the quality assurance coordinator.</p> <p>Lyndale Villa and Lyndale Manor are certified to provide rest home level care and rest home dementia services. There are 28 beds in Lyndale Villa and eight rented supported living units that are also certified. Twenty three rest home beds and seven supported living units were occupied on the first day of the audit. There are 20 beds in Lyndale Manor and 17 were occupied on the first day of the audit.</p> <p>Lyndale Rest Home Services Limited has contracts with the District Health Board (DHB) to provide aged related residential care (rest home and dementia services), short term residential care – Lyndale Villa, and respite services.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the general manager be absent. The general manager reported the quality assurance coordinator fills in for the general manager if they are absent and one of the other registered nurses fills in for the clinical leader. The general manager, quality assurance coordinator and the clinical leader confirmed their responsibility and authority for these roles.</p> <p>The prospective provider advised there will be no changes to the roster and on call arrangements.</p> <p>Services provided meet the specific needs of the resident groups within the facilities.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The prospective provider advised they are not proposing to change any of the policies and procedures following purchase. Policies and procedures have been reviewed by the quality assurance coordinator and are current. Staff confirmed that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>A quality and risk management plan was reviewed and is used to guide the quality programme and includes goals and objectives.</p> <p>The resident and relative satisfaction survey for Lyndale Villa and the relative satisfaction survey for Lyndale Manor were collated in 2015 and results indicated that residents and families were positive to very positive with the services provided.</p> <p>Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. Quality improvement data provided evidence the data was being collected, collated, and comprehensively analysed to identify trends and corrective actions developed and evaluated.</p> <p>The general manager reports to the owner monthly. Staff meetings are held monthly and minutes were reviewed. There was documented evidence of reporting on numbers of various clinical indicators and</p>

		<p>quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the staff areas. Observations during the audit confirmed this.</p> <p>A newsletter is produced which keeps residents and families informed with what is happening at Lyndale Villa and Lyndale Manor.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The prospective purchaser advised they are not aware of any legislative compliance issues that could affect the service.</p> <p>Staff document adverse events on an accident/incident form and these are reviewed by a registered nurse before review and sign off. Adverse events are collated by the quality assurance coordinator at the end of each month, graphed and reported at the weekly clinical meetings and monthly staff meetings.</p> <p>There is an open disclosure policy. Residents' documentation reviewed provides evidence of communication with families/next-of-kin/enduring power of attorney (EPOA) following adverse events involving the resident, or any change in the resident's condition.</p> <p>Staff confirmed they are made aware of their notification responsibilities through job descriptions and policies and procedures, which is confirmed via review of documentation. Policy and Procedures comply with essential notification reporting (e.g., health and safety, human resources, infection control). The general manager advised there have been no notifications of significant events made to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Written policies and procedures in relation to human resources management are available. Staff files evidenced employment agreements and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. There was no evidence of reference checks,</p>

		<p>not all staff have job descriptions, current performance appraisals or police vetting.</p> <p>The education programme for 2015 was reviewed and education is provided by way of monthly education sessions following the monthly staff meetings. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is not being attended by the majority of staff. Competency assessment questionnaires are current for care givers and the registered nurses are currently renewing their competencies for medication management. There was no evidence of restraint competencies for clinical staff. Two of the three registered nurses have the required interRAI assessments training and competencies.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules including dementia. Staff are also supported to complete education via external education providers.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The orientation process, including completion of competencies have been completed. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The prospective provider reported that they are not proposing to make any changes to the existing roster and staffing levels.</p> <p>The rosters for the current service provider were reviewed and the minimum cover is provided at night. There are two caregivers rostered on duty between 11 pm and 7 am at both Lyndale Villa and Lyndale Manor. The general manager and the three registered nurses are rostered on after hours.</p> <p>Caregivers interviewed reported that there are enough staff on duty and they are able to get through the work allocated to them. Residents and families interviewed report there is enough staff on duty to provide them</p>

		or their relative with adequate care.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Hard copy information is kept in the nurses' stations. Archived material is well organised and easily retrievable.</p> <p>Detailed resident progress notes were completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes clearly identify the name and designation of the person making the entry.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admission processes were outlined by the clinical nurse leader and the quality manager. Residents can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service (Focus). The service works closely with both Focus and the Wairarapa District Health Board to ensure entry processes are undertaken in a timely and planned manner. The clinical nurse leader advised that a registered nurse visits all prospective residents being transferred from the hospital, and also visits any hospitalised residents prior to their return to the facility, to ensure that they meet the entry criteria.</p> <p>Prospective residents are provided with detailed information about the service, including the admission criteria and the processes that must be completed prior to admission. They and their family/whānau are encouraged to visit the facility prior to admission.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The clinical leader advised that registered nursing staff use the DHB's</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>'yellow transfer envelope' system to facilitate transfer of residents to and from acute care services. When a resident is transferred a copy of their care plan, medication chart, advance directive, resuscitation status, most recent progress notes, and a referral form go with the resident. Examples of completed referral forms were sighted in the file of a resident previously transferred to an acute facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>All aspects of medication management comply with legislative requirements and safe practice guidelines, except for ensuring that medications are discarded and replaced when past their expiry date.</p> <p>Registered nurses and senior caregivers administer all medication in the facility. Care givers have current competencies and registered nurses are currently renewing their competencies for medication administration. An observation of two medication rounds confirmed that medications were administered in a safe and appropriate manner. All medication charts reviewed contained a current photograph of the resident, their allergy status was recorded, medications were prescribed appropriately, reviewed regularly and medication administration records were complete.</p> <p>Medications are supplied to the facility using the blister pack system. Evidence was sighted that these packs are checked against the medication chart on arrival to the service by a staff member who has current medication administration competency. A stocktake of all controlled medication is undertaken weekly, and a record was sighted of the last six-monthly medication review undertaken by the pharmacist in April 2015.</p> <p>There are currently no residents who are self-medicating, although processes are in place for this should it be required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Experienced and appropriately qualified staff are responsible for food services within the service, which runs two separate kitchens, one for the rest home and the other for the specialist dementia centre. The cooks for both facilities have completed NZQA Unit Standard 167 food safety qualifications as seen in records sighted. On inspection, both</p>

		<p>kitchens were maintained, clean and tidy. Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted, together with evidence that fridge and freezer temperatures were monitored daily and remained within recommended ranges.</p> <p>Both kitchens catered for a range of nutritional requirements, including diabetic, vegetarian, gluten-free and soft diets. A four weekly menu, with summer and winter options, was last reviewed by a registered dietitian in July 2014. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboards. Residents are weighed monthly and nutritional supplements administered as prescribed. Specialised crockery, such as lip plate and feeding cups, is available. There are a number of dining areas for residents to use or they may have meals in their own room if they wish.</p> <p>The general manager is following up to ensure processes associated with the collection of food scraps from both facilities are consistent with Ministry of Primary Industry requirements.</p> <p>Residents and family members spoke of their enjoyment of meals, and appreciated how meals were tailored to meet their individual preferences. The results from the 2015 satisfaction survey also indicated residents were satisfied with the quality and variety of food provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The quality assurance manager advised that if a prospective resident did not meet the entry criteria, or there was currently no vacancy, then they would work with Focus to support the resident/family to make alternative arrangements. The general manager maintains a register of declined admissions.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>A registered nurse completes an initial assessment and care plan for all residents within 24 hours of admission. The initial care plan is developed utilising a range of information provided by the resident/family, the NASC assessment, clinical assessments, such as falls risk and pressure</p>

		<p>area risk, together with the interRAI assessment and any other relevant referral information. Within three weeks of admission a long term care plan is developed. All residents' records reviewed demonstrated evidence of a comprehensive assessment process by the registered nurse, which had been completed in a timely manner and also documented resident/family involvement.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>All of the residents' records reviewed contained an individualised care plan which provides guidance for care delivery staff to support rest home residents' needs. There was a strong emphasis in the care plans of the abilities of each resident, and strategies for maintaining or improving those ability levels.</p> <p>The same care planning format is also used for residents requiring specialist dementia care, and contains limited information to guide care delivery staff in minimising and responding to challenging behaviours, or meaningful activities for that resident over the 24-hour period.</p> <p>The information generated by the interRAI system is generally well incorporated into the care planning process, although this is an area that registered nurses identified they are still working on. The development of short-term care plans when clinical needs change was a strength of the service. There are well-established processes in place to ensure care delivery staff are aware of the short term care plans, and these plans were evaluated and updated in a timely manner.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>All 11 care plans reviewed included evidence of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Detailed entries were sighted in the residents' progress notes especially when there were any changes to resident's needs. Caregivers have access to registered nurses 24 hours a day if they require support and guidance with residents' care delivery. On interview the doctor stated they had no concerns relating to service delivery.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The services' activities programme is led by a diversional therapist (DT) who expects to have completed DT training by November 2015. The DT is supported by two recreation officers, one of whom has commenced DT training. A formal activities programme is provided to rest home residents for four hours each weekday, and for six hours each weekday for residents requiring specialist dementia care.</p> <p>The DT advised that residents' previous and current interests are assessed on admission, individual activity plans completed within three weeks and reviewed six monthly. This was confirmed in residents' records. These plans help inform the development of the monthly activity programme. Activities for the rest home included guest speakers, quizzes, reminiscence, craft, church services and outings in the facility van. Activities are provided both in a group and one-on-one basis. During the on-site visits residents were observed enjoying a range of activities.</p> <p>A separate activities programme is developed for residents requiring specialist dementia care. This includes crafts, bingo, sing-a-long sessions, games, outings in the van, exercises and happy hour. The individual activities plans for these residents do not include meaningful activities over the 24-hour period, and the formal activities plan does not include plans to guide caregiving staff when the activities staff are not present, such as in the late afternoon and at weekends.</p> <p>While all rest home residents/families interviewed expressed satisfaction with their activities programme, one family member of a resident requiring specialist dementia care expressed concern about the lack of activities at the weekend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations of resident progress towards achieving identified goals was undertaken by registered nursing staff, and included clinical reassessments as part of the evaluation process. When progress was different from expected, care plans were updated accordingly. The clinical nurse leader advised that care plans are evaluated at least six monthly and more frequently if clinically indicated. In three of the eleven care plans reviewed these evaluations had not been completed within those timeframes – refer to Criterion 1.3.3.3. Short term care plans were</p>

		evaluated and updated on a very regular basis.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>PA Moderate</p>	<p>The rights of residents to access other health and/or disability providers is maintained. If the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance. Copies of a number of referrals to specialist services were sighted in the residents' files reviewed, including referrals to the dietitian, lymphedema nurse, and palliative care services. Residents/families confirmed on interview that they are kept informed about the referral processes. Support is available to transport and accompany residents to external health-related visits, and/or transfer to hospital. The service has a house doctor, but residents have the opportunity to use another doctor if they so wish.</p> <p>All residents must have a completed Needs Assessment completed by Focus prior to admission to the service, which includes establishing their required level of care. A resident receiving specialist dementia care had not been referred back to Focus for reassessment despite significant changes in the resident's condition.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes are in place for the management of waste and hazardous substances, including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety has not been provided as part of the staff in-service education programme (Refer to 1.2.7.5). Staff could not remember when they had last received training to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents, including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled were provided and being used by staff. For example, gloves, aprons, and masks and visors.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The prospective provider advised they have no plans to make environmental changes to the facilities.</p> <p>Current building warrants of fitness are displayed that expire on the 30 June 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The testing and tagging of equipment and calibration of bio-medical equipment is current.</p> <p>There is a proactive and reactive maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. However, at both Lyndale Villa and Lyndale Manor repairs are required because of rain water damaged areas.</p> <p>There are several external areas available that are safely maintained and are appropriate to the resident groups and settings. The environments are conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.</p> <p>Residents and families confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents are able to move freely around the facilities and Lyndale Manor is spacious with an internal walking circuit. Accommodation meets residents' needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The majority of bedrooms in both facilities have full ensuites. There are an adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Communal toilets and showers have a system that indicates if it they are</p>

		vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents and allow staff and equipment to move around safely.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policies and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.</p> <p>All linen is washed on site and there is a dirty to clean flow provided in the laundries. Laundry personnel are responsible for the management of laundry. The laundry personnel described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>Both facilities are cleaned to a high standard. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described the cleaning processes. Residents and families stated they were satisfied with the cleaning and laundry service. This finding was confirmed during review of the satisfaction survey questionnaires.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these</p>

		<p>areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Documented systems were in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification were available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors were available. There are sensor lights positioned around the facilities and staff can also use the TV at Lyndale Villa to view the external areas if required.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 28 April 2009 for Lyndale Villa and 23 March 2012 for Lyndale Manor was sighted. The last trial evacuation was held on 17 September 2015 at Lyndale Villa and on 6 May 2015 for Lyndale Manor. Not all staff have attended a trial evacuation in the last 12 months (Refer to 1.2.7.5).</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, cell phones and a generator.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach, and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>Covered areas outside the buildings are available for both residents and staff who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Infection control management at both facilities is guided by an infection control manual developed by an external provider which has been tailored to meet the requirements of this service. The manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention and sharps management and single-use items. This manual is reviewed annually, with the last reviewed being undertaken in February 2015.</p> <p>The clinical leader is the designated infection control coordinator. Infection control matters, including surveillance results, are reported weekly at the clinical meeting, and at monthly staff meetings, as sighted in meeting minutes. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings and at staff handover meetings. This was confirmed in staff interviews.</p> <p>A sign at the main entrances to both facilities asks anyone who is or has been unwell in the past 48 hours to not enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator is a registered nurse, who has three years' experience in the role. They are also able to use a range of established networks, such as with the infection control team at the Wairarapa DHB when additional support/information is required. The coordinator is booked to do infection control training in October 2015.</p>

		<p>Refer to criterion 1.2.7.5. The coordinator advised that in her infection control capacity she has access to resident records and diagnostic results to ensure timely treatment and resolution of infections.</p> <p>Protective equipment, including hand sanitisers, gloves, and aprons, is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted).</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>A comprehensive policy/procedure manual, developed by an external provider, guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is reviewed annually, with the last review being undertaken in February 2015.</p> <p>Housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing gloves as appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control is a component of the staff orientation programme, as confirmed in staff orientation/induction records. Annual staff education related to infection control is also provided, and was last completed in July 2015 – refer to Criterion 1.2.7.5. The infection control coordinator advised that infection control is also discussed at staff meetings, and is part of the annual staff appraisal process. Additional staff education is also provided on an as-required basis, such as if there was an infection outbreak or if there were an increased incidence of resident infections with eye infections. Education with residents is generally on a one-to-one basis, and by information in the quarterly resident newsletters. This may include reminders about handwashing or strategies to minimise the possibility of urinary tract infections.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>Surveillance of an appropriate range of infections is undertaken on a monthly basis. This includes data related to skin/wounds, lower</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>respiratory tract, urinary tract, eye and gastrointestinal infections. A record is kept of all antibiotic use, and an infection control form is completed for each infection. These forms are reviewed monthly and analysed by the infection control coordinator, who develops the monthly surveillance report. The quality coordinator produces graphs that demonstrate trends across the service.</p> <p>The coordinator develops the monthly surveillance record with data entered into an extensive database. Graphs are produced that demonstrate trends across the facility since 2011.</p> <p>The monthly surveillance results are reported to the general manager, and discussed with the facility owner as required. Surveillance results are also reported to the monthly staff meeting, which was confirmed in the meeting minutes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enablers is congruent with the relevant standard. There are no residents using restraint or enablers and the restraint coordinator advised restraint has not been used for a number of years. Staff were able to describe the process should restraint be required.</p> <p>Not all staff have received on going education on the use of restraints, enablers and the management of behaviours of concern and clinical staff do not have competency assessments relating to restraint minimisation and safe practice (Refer to criterion 1.2.7.5).</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	<p>Twelve staff files sampled evidenced employment agreements and completed orientations. Copies of annual practising certificates were current for all staff and contractors that require them to practice. None of the staff files had evidence of reference checks. Four of the twelve files did not have job descriptions and current performance appraisals on file. Eleven of the twelve files had no evidence of police vetting.</p>	<p>Not all recruitment and human resource requirements were evidenced in the staff files reviewed.</p>	<p>Provide evidence that recruitment and human resource requirements are completed for all staff.</p> <p>30 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p>	PA Moderate	<p>An education programme for 2015 evidenced on going education is provided monthly apart from chemical training which has not been provided for several years. Although care staff stated they do attend training, individual</p>	<p>There is minimal attendance at training sessions by some care staff. The infection control coordinator has not attended any training with regards to infection prevention and control and this</p>	<p>Provide evidence that (i) all staff receive on going education; (ii) all clinical staff have current competencies for restraint; and (iii) the</p>

<p>services to consumers.</p>		<p>education records showed minimal ongoing education attendance by many care staff. Not all staff have attended a fire drill in the last 12 months and the infection control coordinator who has been in this role for three years has not attended any training with regards to infection prevention and control.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules including dementia modules. The quality assurance coordinator is the internal assessor.</p> <p>Competencies are current for all staff who are responsible for medicine management. There were no restraint competencies for clinical staff.</p>	<p>was arranged during the audit. Competencies for restraint were not evidenced for clinical staff.</p>	<p>infection control coordinator has completed appropriate training.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>With the exception of the management of expired medications, all other aspects of the medication management system comply with legislation, protocols and guidelines.</p> <p>While most medications in the medication trolleys was within current use-by dates, at least four packs of as-required medications in both facilities had expired, and four medications in the stock cupboard in the specialist dementia centre had also expired.</p>	<p>Medications are not being checked regularly to ensure they remain within current use-by dates.</p>	<p>There are systems in place to ensure that medications are discarded when they have expired.</p> <p>180 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The assessment of resident care needs and the development of plans to address those needs are completed within appropriate time frames. The evaluation of short term care plans was undertaken on a timely basis, but in three of the 11 residents' records reviewed evaluations of long-term nursing care plans had not been completed within the required six-month time frame.</p>	<p>Evaluations of nursing care plans are not consistently completed within the required six-monthly time frame.</p>	<p>Nursing care plans are evaluated at least six-monthly, and earlier if clinically indicated.</p> <p>180 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The care planning format used by the service includes hygiene, skin integrity, elimination, nutrition, pain management, sleep and settling, cultural needs, mobility, vision, communication, memory/cognition, restraint, spiritual and psychosocial needs. In all of the six rest home residents' files reviewed care plans detailed the support/interventions required to meet identified needs.</p> <p>For residents requiring specialist dementia care, the same care plan format is used. None of the five files reviewed for these residents included detailed information related to identifying the triggers for behaviours of concern, how to minimise these behaviours, or manage them should they occur. Behaviour charts are maintained to document episodes when behaviour is of concern, but there is no plan in place to minimise these behaviours.</p> <p>Each resident had an individualised activities plan developed, which was</p>	<p>Residents requiring specialist dementia care do not have detailed care plans related to minimising episodes of challenging behaviour or descriptions of how behaviour is best managed over the 24-hour period.</p>	<p>Residents receiving specialist dementia care have a detailed care plan in place that includes strategies for minimising episodes of challenging behaviour, and managing such behaviours over the 24-hour period.</p> <p>90 days</p>

		evaluated at least six-monthly. The plans for residents requiring specialist dementia care did not include details of meaningful activities that could be undertaken with residents over the 24-hour period. (Refer also to Criterion 1.3.7.1)		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Each resident has an individualised activities plan, which is completed within a timely manner, and evaluated at least six-monthly. Records were sighted of individual resident participation in the activities programme.</p> <p>The current format for activity planning, while appropriate for residents receiving rest home level care, does not include all the required information for residents requiring specialist dementia care. In particular, there was no evidence in the five plans reviewed of an activity plan for each of those residents which covers the 24-hour period, as required in the DHB contract.</p> <p>There is a diversional therapist/recreation officer on site at the specialist dementia centre for six hours every weekday. The activities plan for these residents includes a range of individual activities, exercises, games, entertainment and outings. The diversional therapist reported that a variety of 'activity pods' (which include for example, jigsaws and games) are available for staff to use in the late afternoons, evenings and at weekends, but there is no formal plan</p>	<p>Residents requiring specialist dementia care do not have activity plans for the 24-hour period, as required by the DHB contract.</p> <p>There is no formally-planned activity programme for residents requiring specialist dementia care when the diversional therapist/recreation officers are not onsite, including late afternoons and weekends.</p>	<p>All residents receiving specialist dementia care have an individualised 24-hour activity plan.</p> <p>An activities plan is in place to guide care delivery staff working with residents requiring Stage III dementia care which includes suggested activities for late afternoons and weekends.</p> <p>180 days</p>

		that sets out suggested activities for care delivery staff to use on an organised basis. One of two family members interviewed expressed concern about the scarcity of activities at the weekends for these residents.		
<p>Criterion 1.3.9.1</p> <p>Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.</p>	<p>PA</p> <p>Moderate</p>	<p>All residents entering the service must have their support needs level assessed and confirmed by the Needs Assessment and Service Coordination service (Focus). These assessments were sighted in all residents' files reviewed.</p> <p>Three residents receiving specialist dementia care have experienced changes to their mobility status which have the potential to impact on their care needs level. All three residents can weight bear, but not necessarily mobilise independently. For two of those residents, their mobility status has fluctuated over the past two months, but caregiving staff reported that a third resident has been immobile for a number of months. That resident has not been referred back to Focus for reassessment. The resident requires two-hourly turning when in bed, must be fed all food and fluids, and the progress notes consistently record 'nil mobility'. The resident last had an evaluation of their progress towards meeting identified goals in January 2015. The clinical leader advised that the interRAI assessment for this resident will be completed in the near future.</p>	<p>Residents are not being referred for reassessment of their care need level in a timely manner when their condition changes.</p>	<p>Residents are promptly referred for reassessment of their care need level as clinically indicated.</p> <p>180 days</p>

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The building warrants of fitness are current for both facilities. There is a proactive and reactive maintenance programme in place and the maintenance person is responsible for managing any reactive maintenance. Hot water temperatures monitored at resident outlets are 45 degrees Celsius or below.</p> <p>At Lyndale Villa the roof over the porch where the chemicals are stored leaks and when it rains water runs into the laundry. As a result the vinyl around the dryer is cracked and water leaks through. At Lyndale Manor, although the roof has been fixed, as a result of a water leak in the passageway opposite the dining room, the flooring is lifting and the floor underneath is spongy.</p>	<p>Repairs and maintenance are required: (i) to the roof over the porch and the vinyl in the laundry at Lyndale Villa; and (ii) to the flooring that is lifting and the area underneath that is water damaged at Lyndale Manor.</p>	<p>Provide evidence that repairs and maintenance is carried out at both facilities where there has been water damage.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.